

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN3314	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/09/2014
NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF CHATTANOOG		STREET ADDRESS, CITY, STATE, ZIP CODE 8249 STANDIFER GAP ROAD CHATTANOOGA, TN 37421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments A Licensure survey was completed on December 9, 2014, at Consulate Health Care of Chattanooga. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		1/12/2015	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

GM4111

If continuation sheet 1 of 1